Dr Paul Farrant
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Patient Information Leaflet

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Frontal Fibrosing Alopecia

What is Frontal Fibrosing Alopecia (FFA)?

FFA is a type of scarring hair loss that is thought to be a variant of lichen planus that affects the frontal hairline. Inflammation around the hair follicle causes destruction of the follicle, which is then replaced with scar tissue. It predominantly affects post-menopausal women.

What causes FFA?

The cause of FFA is unknown. The condition typically affects post-menopausal women and can co-exist with female pattern (androgenetic) hair loss, which has led to speculation that changes in hormones may be partially responsible. No abnormality in hormone levels has been found.

Is FFA inherited?

FFA is not thought to be inherited, but family cases have been reported and the potential genetic susceptibility of this condition is being investigated.

What are the symptoms?

FFA typically causes very few symptoms. In contrast to other forms of lichen planus, itch is frequently absent. The most common complaint is a receding hairline.

What does FFA look like?

FFA causes loss of hair affecting the frontal hairline, eyebrows and occasionally body hair. This results in a band of skin with either no hair or sparse hair, which is usually paler than the chronic sun exposed forehead. Redness around the hair follicle is common. The area of recession progresses slowly over several years, although occasionally this process can be rapid. Infrequently other features of lichen planopilaris or lichen planus may be evident, with more diffuse hair involvement (usually itchy), or oral, genital, nail or skin lesions.

Can it be cured?

When hair follicles have been destroyed they cannot re-grow. The hair loss is therefore irreversible. The condition may burn itself out after several years but slow progression over many years is common. There are treatments aimed at stopping further destruction of the hair follicles.

How can FFA be treated?

FFA can be treated with topical treatments, such as steroid lotions and tablets. The evidence for any of the treatments in this condition is poor.

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Topical & Intralesional Steroids
Potent topical steroids in the form of lotions, gels or mousses can manage localised disease. Injection of a steroid may be an option if only a small area is involved.

Systemic Steroids
Short courses of oral steroids can be used to try and switch off the attack, but side effects limit the long term use of oral steroids.

Tetracycline Antibiotics
This family of antibiotics are frequently used as anti-inflammatory treatment. They require little monitoring and are often used for long courses e.g. 6 months or more.

Hydroxychloroquine
Although slow to act, this member of the anti-malarial family can be useful in this condition. Although this particular anti-malarial is not associated with eye problems, it is recommended that patients have an annual eye check on treatment and six monthly liver function tests.

Mycophenolate mofetil This is a powerful immunosuppressive drug most commonly used in patients who have had a kidney transplant. This treatment works by suppressing the immune system. Gastrointestinal side effects are common and regular blood tests are required until established on treatment.

5α Reductase Inhibitors
These medications are anti-androgens and are licensed in men with prostate disease. Experts sometimes use them off license in an experimental fashion, but strict monitoring is required.

Where can I get more information?
http://www.dermnetnz.org/hair-nails-sweat/frontal-fibrosing-alopecia.html

http://emedicine.medscape.com/article/1073559-overview

http://www.carfintl.org/